# STATE OF CONNECTICUT
# State Innovation Model
## *Equity and Access Council*
## *Design Group 4 – Retrospective and Concurrent Monitoring*
## *Design Workshop #1*

**Meeting Summary**
**Thursday, February 12, 2015**
**12:00 – 1:00 p.m.**

**Location:** By Webex and Conference Call

**Members Present:** Ellen Andrews; Alice Ferguson; Gaye Hyre; Robert Russo

**Other Participants:** Karen Buckley-Bates; Anthony Dias; Lisa Douglas; Katie Sklarsky; Adam Stolz; Sheldon Toubman

**Agenda Items:**
1. Introductions
2. Public Comment
3. Overview of Design Group Process
4. Retrospective Monitoring and Detection
5. Concurrent Monitoring and Detection
6. Synthesis of Initial Hypothesis

**Meeting Summary:**

The meeting was called to order at 12:02pm.

Katie Sklarsky facilitated a group discussion. Participants articulated a number of perspectives including:

- Patients who are underserved may not realize it. Accordingly, relying on patient-reported grievances and/or patient experience data (e.g.; CAHPS) alone is an insufficient monitoring mechanism.
- Sequencing of recommendations matters. As was done with the Health Neighborhood monitoring recommendations, the group should define what it believes should be monitored for prior to defining who it believes should conduct the monitoring, or what source should be used. On the other hand, no matter what type of monitoring is performed, the state will have a prominent role to play unless a clear business case for payers or providers to do the monitoring is established.
- Members have additional suggestions for what types of monitoring should be conducted. Members are encouraged to submit suggestions to Katie Sklarsky by email (ksklarsky@chartis.com).
- Monitoring should include identifying any patterns of selection for patients with clinical conditions that afford especially large opportunities to earn shared savings. While it is not inherently problematic for providers to embrace complex patients in response to financial incentives, there is a concern about "crowding out" patients where the incentive is not prevalent, potentially leading to a narrowing of access if primary care providers begin to specialize in treating patients with certain diagnoses.
- One monitoring technique may be to mine claims to data to identify variance in the rate of interventions per patient with a particular diagnosis. Comparing ACOs to each other, or comparing the ACO-served population in aggregate to the purely FFS-served population, may be a viable method. Differences identified will need to be probed to determine if they are beneficial (e.g.; reduction of redundant, unwarranted, or harmful interventions) or inappropriate (e.g.; reduction of warranted interventions in favor of cheaper interventions or no interventions).
    - Crystal Run used dollars as a first cut to identify over/under utilization between providers, this should be used in addition to understanding variations of specific interventions

- For the OHA nurse consultant role:
    - There should be a position dedicated to addressing instances of under-service and patient selection. While it may be useful to add under-service and patient selection to the "filter" that all nurse consultants apply in evaluating patient disputes, it is important that a resource be dedicated to these issues in order for them to be addressed in a meaningful way.
    - The nurse consultant should play a proactive as well as reactive role. The position should take intelligence gleaned from monitoring activities (e.g.; data analysis, mystery shopper) and conduct investigations.
    - The nurse consultant should monitor outcome data in addition to utilization data to understand if interventions being used are successfully addressing equity and access concerns. Some examples of the type of outcomes to measure could include, depression rates, needs for medication, ER use and/or patient/care giver satisfaction.
    - The nurse consultant should be a part of a larger group identified to monitor for "seminal events" for which special studies should be conducted to evaluate potential issues. Historically these studies have been effective at improving aspects of Medicaid in CT. Monitoring of "seminal events" and the accompanying special studies should be conducted by various groups, not concentrated in one area and should promote transparency.
    - Monitoring admission and readmission data or other gaps in care transitions may be a way to identify patterns of complex patients who are not getting care management services that one would expect them to receive if they were getting attributed to ACOs. While this could be helpful, it is important to note that comprehensive standards of care do not exist today, which will make this methodology a challenge.
- For the mystery shopper role:
    - This can be an effective tool. Prior efforts by DSS provide a good model.
    - The mystery shopper could dovetail with the nurse consultant. When potential under-service or patient selection is identified, a nurse consultant should investigate, applying a clinical lens.
- Concurrent monitoring could also include:
    - Peer review of provider performance/panel composition
    - Reviewing access to different services by geographic area
    - Reviewing insurance plans to identify ways that drug tiering or other aspects of benefit structure (i.e.; selective provider panels) may affect coverage and inclusion in ACOs of patients with certain clinical conditions
- No monitoring mechanism will be perfect. We need to identify ways of detecting under-service that is occurring and is not currently on our radars. An example would be underservice that results from lack of provider resources to care for certain populations (e.g.; turning a large patient).

The meeting adjourned at 1:00pm.